North Carolina Department of Health and Human Services
Michael F. Easley, Governor
Dempsey Benton, Secretary

Division of Mental Health, Developmental Disabilities and Substance Abuse Services
3001 Mail Service Center
Raleigh, North Carolina 27699-3001
Tel 919-733-7011• Fax 919-508-0951
Michael S. Lancaster, M.D. and
Leza Wainwright, Directors

Division of Medical Assistance
2501 Mail Service Center
Raleigh, North Carolina 27699-2501
Tel 919-855-4100 • Fax 919-733-6608
William W. Lawrence, Jr., MD, Acting Director

May 5, 2008

MEMORANDUM

TO:
Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: William W. Lawrence, Jr., MD

Leza Wainwright

SUBJECT: Implementation Update #43:
Transition from State Operated Facilities
De-Institutionalization Slot Allocations
CAP-MR/DD Waiver Update
Incident and Death Reporting
NEA Withdrawal Routing
PCP Updates to ValueOptions
Maintenance of Service: TFC and TCM
Out-of-State Enrollment of Residential Services
Provisionally Licensed Providers & "Incident To"
Halfway House and Social Setting Detox Service
NCI Professional Requirements
New Service Rates

Transition of Individuals from State Operated Facilities to the Community

North Carolina continues to move forward with the downsizing of state operated developmental centers in accordance with the U. S. Supreme Court Olmstead decision. In order to ensure that every opportunity is provided to individuals/guardians who have expressed an interest in transitioning from a developmental center or state hospital to the community, ongoing communication amongst state operated facilities, Local Management Entities (LMEs), and providers is essential. Although individuals/guardians may have expressed an interest in community living, or an individual has been identified for discharge from a state facility, without awareness of the appropriate community residential settings available and clear processes for transition planning, movement to the community will be neither timely nor successful. In order to support effective communication and planning, the processes that must be in place are outlined in **Appendix A**.

De-Institutionalization Slot Allocations

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) set aside CAP-MR/DD waiver slots in March of 2007 in order to address the needs of individuals with intellectual or developmental disabilities (IDD) in state operated facilities that are in need of supports and services to transition to the community. These slots are maintained and allocated by staff of the Best Practice Team at the DMH/DD/SAS. A slot is considered to be a De-

Institutionalization (DI) slot when it is used to support an individual transitioning to the community from a state developmental center. A general guideline used in allocation of DI slots is that the individual has resided in the developmental center for at least 180 days and/or has had two or more admissions to a state hospital within a year. In order to ensure that DMH/DD/SAS staff has adequate information to make an appropriate decision as to the appropriateness of allocating a DI slot, and to ensure that a transition from an institutional setting to the community using CAP-MR/DD funding is successful, the following process must be followed:

All requests for a DI slot must come through the appropriate LME and must include the following information in password protected format:

- Identifying information of the consumer, including name and last four digits of the Medicaid ID number, and home LME in a password protected document.
- A psychological evaluation inclusive of an adaptive functioning assessment that has been completed or updated within the last year for a child or within three years for an adult. If an up to date psychological evaluation is not available, confirmation that an update is in process must be provided.
- Any additional assessments such as psychiatric evaluations that may impact the decision.
- Information regarding the identified community residential placement, including confirmation of the provider's willingness to serve the consumer.
- Confirmation that a crisis plan will be written in collaboration with the state facility, LME, and the community provider that assures the roles of all parties in the event of a crisis.
- A behavior support plan developed by a licensed psychologist when behavioral challenges are identified. This may be developed by or in collaboration with the state facility but must be overseen in the community by the appropriate licensed psychologist.
- A basic transition plan including projected date of discharge developed in collaboration with the LME, identified community providers and the facility.
- If additional state funding is needed to supplement the waiver funding there must be commitment from the LME that state funds are available for the specific consumer to the extent possible.

Once a DI slot has been allocated, the staff of the Best Practice Team at the DMH/DD/SAS will receive updates as to the status of the community placement every 30 days. The contact person for DI slots is Sandy Ellsworth at sandy.ellsworth@ncmail.net. Note: In addition to the above, LMEs must adhere to all requirements included in the *Contract Requirements between LMEs and State Facilities.*

CAP-MR/DD Waiver Update

As we have discussed over the past several months, our staffs have been actively engaged with a broad-based stakeholder group to develop the series of tiered waivers mandated by the General Assembly in the current year Appropriations Act. The federal Centers for Medicare and Medicaid Services (CMS) have notified us that we will not be able to extend our current waiver beyond October 31, 2008. In order to ensure as smooth a transition as possible and stay within the deadlines established by CMS, we have decided to move forward with the tiered waiver approach in phases. Therefore, we will concentrate our efforts over the next several months to finalize the replacement comprehensive waiver and develop the Tier 1 Supports and Self-Direction waiver. Once those waivers are approved and implemented successfully we will then move to develop additional tiers. We believe this approach will cause the least confusion and transition problems for consumers and families served through the current waiver and continue our progress to meeting the expectations of the General Assembly.

Incident and Death Reporting

Incidents and deaths must be reported on the Department of Health and Human Service (DHHS) Incident and Death Report Form QM 02 (see below link to access form): Providers of publicly funded services licensed under NC General Statutes 122C, Category A providers (except hospitals), and providers of publicly funded non-licensed periodic or community-based DMH/DD/SAS, Category B providers, must submit the form. Failure to do so, as required by North Carolina Administrative Code 10A NCAC 27G .0600, may result in DHHS taking administrative action against the provider's license or authorization to provide services. **This includes CAP-MR/DD, periodic MH/SA and residential providers**.

All Level II consumer incidents (including deaths from terminal illness/natural cause) must be reported to the host LME. All Level III consumer incidents (including sexual assault and deaths from suicide, accident, homicide/violence and unknown cause) must be reported to the host LME, home LME and the DMH/DD/SAS Quality Management Team.

The DHHS incident reporting forms and manual can be accessed at: http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/index.htm. Scroll down to *Incident and Death Response System*. Questions should be directed to the host LME. The MH/DD/SAS Quality Management Team may also be contacted with questions at 919-733-0696 or email questions to contactdmhquality@ncmail.net .

Routing of Notification of Endorsement Action (NEA) Submissions for Withdrawal of Endorsement

The following supersedes guidance given in Implementation Update #38, page 4, entitled "Revised Guidance for Routing of Notification of Endorsement Action (NEA) Submissions for Withdrawal of Endorsement."
Effective June 1, 2008, the endorsing agency must submit NEA letters to the Division of Medical Assistance (DMA) via certified mail to: DMA Provider Services, 801 Ruggles Drive, Raleigh NC 27699-2501 or electronically to endorsement.dma@ncmail.net. The endorsing agency shall copy DMH/DD/SAS at: endorsement.accountability@ncmail.net. This guidance is in accordance with DMH/DD/SAS Policy and Procedure for Endorsement of Providers of Medicaid Reimbursable MH/DD/SAS Services dated 12/3/2007.

Please ensure that the NEA letters submitted to DMA are signed by the endorsing agency CEO for voluntary and involuntary withdrawals. Unsigned NEA letters will not be accepted by DMA.

Updated Person Centered Plans to ValueOptions

As stated in Implementation Update (IU) # 39, providers are required to submit the update or revision page of the Person Centered Plan (PCP) with **all concurrent requests for all applicable levels of service** to ValueOptions (Please refer to IU #39 for the specifics on submitting PCP updates). The update/revision must be signed by the qualified professional and the consumer or legally responsible person to be valid. Please note that this update should be no earlier than 30 days prior to the concurrent request. Without this update ValueOptions can not process the request.

Maintenance of Service: Therapeutic Foster Care and Targeted Case Management

This update is intended to outline the process for Maintenance of Service authorizations specific to Therapeutic Foster Care and Targeted Case Management including:

- Under what circumstances Maintenance of Service applies
- How ValueOptions is alerted to enter these authorizations
- How providers and LMEs can determine if there is an active authorization in ValueOptions system

LMEs are expected to continue to make payments to providers while services that continued to be billed to Medicaid through LMEs are delivered under Maintenance of Service authorizations specific to Therapeutic Foster Care and Targeted Case Management.

Maintenance of Service applies to requests for authorization where a denial or reduction of service has occurred for a **concurrent request** and a valid appeal notice has been received by DHHS or OAH. The denial letter received by the consumer and provider indicates if an appeal is requested, services will continue at the previous level. These authorizations provide continuity of care during the appeal process.
Providers should *not* submit an ITR for Maintenance of Service. ValueOptions will enter the Maintenance of Service authorization within five business days of when the Hearing Office sends confirmation that an appeal has been requested. The units that are authorized can be viewed in Provider Connect, located on ValueOptions' web site at www.valueoptions.com. Providers and LMEs can also contact the ValueOptions EDI Helpdesk (888-247-9311) for instructions on how to use Provider Connect if not familiar with this program.

Because Therapeutic Foster Care and Targeted Case Management authorizations go to the LMEs instead of the provider; LMEs traditionally do not pay providers until the LME receives an authorization letter from ValueOptions. With Maintenance of Service authorizations, no letter will be sent to the LME. However, LMEs can view current authorizations in Provider Connect. It is important to note Maintenance of Service authorizations seen in Provider Connect will appear as a standard authorization. There is no distinction to indicate it as a Maintenance of Service authorization. Thus, if a provider appeals a reduction or discontinuation of service, they are responsible for notifying the LME so that the LME knows to look for the authorization in Provider Connect. LMEs should not refuse to provide payment to these providers if a Maintenance of Service authorization is entered.

Compliance Verification Protocol for Out-of-State Enrollment of Residential Services

It is the intent of the service system to develop and provide medically necessary services and supports for children and youth with serious behavioral health needs and their families in their home community. However, in a few instances, this may not be possible. In these cases, a compliance verification protocol must be completed for a specific child or youth with serious behavioral health treatment needs that meet medical necessity and for whom all clinically appropriate services and in-state resources have been explored and tried without improved outcomes as outlined in the person centered plan.

This compliance verification protocol can be obtained by calling ValueOptions at 1-888-510-1150 extension 292621 and requesting the Out of State Packet. The protocol includes the following components:

- Placement request checklist
- Placement request guideline form
- Placement acknowledgement/support statement

All three of these documents must be followed and fully completed to be accepted before any consideration will be given to the request. Supporting documentation must be attached to the completed and signed request including:

- Person centered plan
- Current comprehensive clinical assessment
- Treatment summaries
- Documentation of all in-state services and supports accessed
- All other items as noted in the protocol checklist and guideline form

In addition, a Child and Family Team representative, the LME Director and the Community Collaborative must be part of this planning and decision-making process for such a referral to be made. The LME Director and the Chair of the Community Collaborative must sign the Out of State placement acknowledgement/support statement agreeing with the referral and assuring compliance with all policies and procedures have been followed and all in-state resources have been exhausted. The request will not be considered complete without all required components and supporting documentation.

Upon submission of the completed request to ValueOptions, the review process will begin and authorization determination made within five business days for enrolled providers. The compliance review of out of state providers is a joint process between DMA and DMH/DD/SAS. Steps for out of state providers include the following:

- ValueOptions contacts DMA, Behavioral Health Section, when the decision has been made to approve out of state placement for a Medicaid recipient.
- DMA contacts the Accountability Section of DMH/DD/SAS to conduct a compliance review of the facility.
- Once the compliance review is completed, DMA is notified of the findings.
- DMA Behavioral Health Section reviews the findings of the compliance review, contacts the Medicaid Agency in the home state of the provider and makes the final decision regarding meeting the standards and qualifications for enrollment.
- Once compliance is determined, the provider is notified of their ability to enroll with Medicaid.
- DMA Rate Setting will establish a rate and DMA Provider Services will enroll the provider upon completion and receipt of an approved application.
- ValueOptions is notified of the findings and to proceed with the process of entering the prior authorization for appropriate payment**.**

For more information please contact susan.robinson@ncmail.net or call 919-715-5989 x228, or contactdmh@ncmail.net.

Provisionally Licensed Providers Billing through Physicians

Effective July 1, 2008, Medicaid enrolled physicians, utilizing the "Incident To" policy, will be able to bill for the services of their employees who are social workers, psychologists, professional counselors, marriage and family counselors, or clinical addictions specialists who are registered with their respective boards and are in the provisional, or board eligible status, and are receiving clinical supervision approved by their respective licensing board required to achieve full licensure status. These provisionally licensed professionals will be able to bill Medicaid and IPRS for contracted services.

With the expansion of direct enrollment for licensed practitioners delivering outpatient services and the divestiture of direct service provision by the LME, individuals who are provisionally licensed have been concerned that they would no longer be successful in obtaining employment during their provisional license period. DHHS has permitted the LMEs to bill for the services of provisionally licensed providers using the LME's Medicaid provider number until June 30, 2008. This temporary measure provided an opportunity for provisionally licensed providers to be employed while they completed the supervised experience required prior to becoming fully licensed. A workgroup from the Division of Medical Assistance and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and representatives from the various provider specialties, have been meeting to develop a proposal to allow provisionally licensed providers to bill Medicaid for services they provide under supervision**.**

The Division of Medical Assistance will expand the "Incident To" policy in order to permit physicians to bill for the services of provisionally licensed providers. For the purpose of this policy, "provisionally licensed" refers to individuals who are under the jurisdiction of one of the following licensing boards and have met the requirements for provisional or board eligible status. These individuals are receiving clinical supervision approved by their respective licensing board and are able to provide clinical services under supervision. These individuals have completed most if not all of their education and training and have passed or are preparing to take their licensing examination. Physicians may employ these provisionally licensed providers and bill for their services utilizing the physician's Medicaid Provider Identification Number. The provisionally licensed providers included in this policy are:

- Psychologists
- Social Workers
- Marriage and Family Therapists

- Professional Counselors
- Clinical Addictions Specialists

These provisionally licensed providers will be reimbursed by Medicaid and state funds on a fee schedule appropriate to the provider specialty. A communication regarding the finalized policy pertaining to provisionally licensed providers will be available in the June Medicaid Bulletin.

In conjunction with this proposal to provide a mechanism for provisionally licensed staff to continue to be paid for outpatient services, the licensing board of each identified specialty group will review all of the new service definitions, and clarify the clinical component of those definitions that they will recognize for supervised credit toward full licensure in the provision of those services.

A separate Communication Bulletin is also being issued today announcing a new DMH/DD/SAS policy regarding the continued eligibility for reimbursement of designated non-licensed substance abuse counseling professionals for identified state funded substance abuse assessment and counseling services. The designated non-licensed substance abuse counseling professionals who are covered under the separate Communication Bulletin are not included in the above "Incident To" policy for provisionally licensed professionals.

Halfway House and Social Setting Detox Service Not Required to Be Nationally Accredited

In the "Enhanced Benefit Services for Mental Health and Substance Abuse Effective March 20, 2006," found at: http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/servicedef1-9-06final.pdf, Substance Abuse Halfway House and Social Setting Detox are in the list among these services but identified as "Not a Medicaid Billable Service." The service definitions specify that the Substance Abuse Halfway House and Social Setting Detox service provider must obtain national accreditation. Since these two SA services are not Medicaid reimbursed services, and are not subject to the same State Plan Amendment (SPA) which governs the other services, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services has determined that the Substance Abuse Halfway House and Social Setting Detox are not required to meet the national accreditation requirement at this time. Should you have further questions about this decision, please contact Spencer Clark at Spencer.Clark@ncmail.net.

Training on Alternatives to Restrictive Interventions and Demonstration of Competency for Licensed Professionals in Community Facilities

North Carolina's legal requirements for restrictive interventions are found at G.S. 122C-60 and in the North Carolina Administrative Code (NCAC). Training on Alternatives to Restrictive Interventions and demonstrated competence in a minimum number of core areas is outlined in 10A NCAC 27E .0107.

Training Requirements

The training requirements under these rules state, "Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented."

The rules also state that training shall be competency-based (per state competencies), approved by DMH/DD/SAS, and formal refresher training must be completed by each service provider at least annually.

Competencies

The rule further states, "Staff shall demonstrate competence in the following core areas:

1. knowledge and understanding of the people being served;
2. recognizing and interpreting human behavior;
3. recognizing the effect of internal and external stressors that may affect people with disabilities;
4. strategies for building positive relationships with persons with disabilities;
5. recognizing cultural, environmental and organizational factors that may affect people with disabilities;
6. recognizing the importance of and assisting in the person's involvement in making decisions about their life;
7. skills in assessing individual risk for escalating behavior;
8. communication strategies for defusing and de-escalating potentially dangerous behavior; and
9. positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe)."

The rule cited above requires that "staff, including service providers," among others, shall demonstrate competence by successfully completing training…" The NCI training (Parts A, B, and C) is the curriculum used for such training across

the state. The minimal requirement is a participant's successful completion of NCI Part A, unless more restrictive interventions are used. Part A covers prevention and alternatives to restraints, seclusion, and isolation time out. Part B covers the use of physical and restrictive interventions. Training in both Part A and Part B is required if an agency will be using physical techniques.

Option for Licensed Professionals
Licensed professionals, by virtue of their extensive training and experience, may elect to either take Part A NCI training, or they may attest to their competence in each of the nine areas outlined above by signing an attestation statement confirming that they have reviewed the nine competencies and that they are proficient and well-skilled in each of these areas. This statement must be submitted to the facility director or CEO for approval and maintained in the licensed professional's personnel file.

Option for Service Providers
North Carolina Intervention (NCI) is the standardized training program to prevent the use of restraints and seclusion created and supported by the DMH/DD/SAS. Agencies may choose to use this curriculum. If NCI is chosen, providers must use certified NCI instructors. Agencies may use training programs of their choice, as long as they are approved by the DMH/DD/SAS. The training can be accessed through a network or approved providers across North Carolina found at the following link: http://www.ncdmh.net/NCI-Public/index.htm.

Agencies may also develop their own curriculum; the curriculum must be reviewed and approved by the state. The Division Curriculum Review Committee reviews curricula based on training competencies. These competencies describe the abilities the trainee should gain during training. They are divided into three sections: prevention, use, and instructor training.

To Apply for Curriculum Review, Send in:

1. Cover letter or memorandum
2. Completed crosswalk(s) – This describes how and where the curriculum handles each competency (instructions are on the forms). These forms are found on the DMH/DD/SAS web site at: http://www.ncdhhs.gov/mhddsas/training/restraintseclusion.htm
3. The curriculum
4. Send this information to: Restraint and Seclusion Prevention Curriculum Review
   Communications and Training Team
   Division of MH/DD/SAS
   3022 Mail Service Center
   Raleigh, North Carolina 27699-3022

New Service Rates
We are pleased to announce that the Secretary has approved new rates for two important services for children, Intensive In-Home and Multi-Systemic Therapy (MST). The new rates will be effective for services delivered on or after June 1, 2008. The new rates are as follows:

Service	Rate	Unit
Intensive In-Home	$258.20	Day
Multi-Systemic Therapy	$ 37.32	15 minutes

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@ncmail.net.

cc: Secretary Dempsey Benton
Dan Stewart
DMH/DD/SAS Executive Leadership Team
DMA Deputy and Assistant Directors
Christina Carter
Sharnese Ransome
Kaye Holder
Wayne Williams
Shawn Parker
Andrea Poole
Mark Van Sciver
Brad Deen

Appendix A: Transition of Individuals from State Operated Facilities to the Community

The following are the processes that must be followed for effective communication and planning of step down transition to community residential settings.

Individuals with Intellectual and Developmental Disabilities (IDD) in Developmental Centers

Developmental Center Functions

- A report listing all individuals whose guardians have expressed an interest in transitioning the person to the community will be submitted by the developmental center transition coordinator to the respective LME DD point of contact (POC) person quarterly. Dates of Plan of Care meetings will also be sent to the LMEs.

Local Management Entity (LME) Functions

It is the responsibility of the LME to be knowledgeable of those individuals in their catchment area who reside at the developmental centers, particularly those individuals who have expressed an interest in community living. An LME representative or designated Targeted Case Management (TCM) provider selected by the resident and their guardian should be available to participate in the planning meetings for individuals who have been identified for community living based on their expressed interest. In addition, the DMH/DD/SAS Director has instructed, through a memo, that each LME identify a staff member as the developmental disability POC at each LME for information sharing and communication purposes. LME functions include:

- Informing the developmental center transition coordinators of the developmental disability POC for their LME.
- LME developmental disability POC receiving reports from the developmental centers transition coordinators listing all individuals/guardians within their catchment area who have expressed an interest in transitioning to the community.
- Maintaining a roster of individuals identified as interested in community living with contact information for all guardians.
- LME provider relations/service staff initiating processes with community providers (including ICF-MR providers) to ensure communication regarding residential vacancies within their catchment area, including a process for notifying individuals/guardians, as well as developmental center transition coordinators, when an opening is available in the community. This also includes identification of and communication with service providers who are interested in supporting individuals in transitioning to the community, particularly those with significant medical or behavioral challenges.
- An LME representative or designated TCM provider, selected by the resident and their guardian, should be available to participate in the planning meetings for individuals who have been identified for community living based on their expressed interest.
- Waiver slots being reserved to support individuals in transitioning to the community. LME staff will interface with MH/DD/SAS staff on the Best Practice Team regarding requests for deinstitutionalization (DI) slots when an individual is identified for community placement and a residential setting is identified. LME staff will follow the DI process throughout the transition. (See "DI Slot Allocation Process" referenced in IU #43 for transition using a waiver slot.)

Individuals with Co-Occurring Intellectual and Developmental Disabilities (IDD) and Mental Illness (IDD/MI), or Persons with IDD Only in State Psychiatric Hospitals

In addition to the above processes regarding individuals in the developmental centers who express an interest in transitioning to the community, a significant number of individuals with co-occurring intellectual or developmental disabilities and mental illness (IDD/MI) and IDD only continue to be served in state psychiatric facilities. Ensuring that these individuals are supported appropriately in the community requires collaboration between the LME and the state hospitals. The SFY08 Performance Contract with the LMEs requires that the LME provide care coordination services for consumers who are being discharged from state facilities, hospitals, or emergency services that do not have a connection with a clinical home provider. This includes participating in discharge planning and continuing to work with the consumer and primary care physician until the individual is connected with a clinical home provider. With this in mind the following should be considered:

State Hospital Functions

- A report listing all individuals with IDD/MI and IDD will be submitted by the hospital liaison to the respective LMEs identified developmental disability POC quarterly along with dates of care planning meetings.

Local Management Entity (LME) Functions

- Informing the hospital liaisons of the developmental disability POC for their LME.
- Ensuring that the developmental disability POC receive from state hospitals the list of individuals who are IDD/MI or IDD.
- Ensuring participation at planning meetings at the state hospitals for individuals who are IDD/MI.
- Ensuring full compliance with the hospital diversion process.
- LME provider relations/services staff identifying providers in their catchment area with expertise in co-occurring IDD/MI disorders, inclusive of case management provider agencies with qualified professionals with competency in IDD/MI. If it is determined that there is a lack of providers with this expertise, efforts should be made to initiate planning to develop the provider community to ensure there are no unmet needs.
- LMEs initiating efforts with community providers to ensure communication regarding residential vacancies within their catchment area, including a process for notifying individuals/guardians, as well as hospital liaisons, when an opening is available in the community.
- The developmental disability POC interfacing with DMH/DD/SAS staff on the Best Practice Team regarding requests for a DI slot when an individual is identified for community placement or discharge and a residential setting is identified. LME staff will follow the DI process throughout the transition.
- Ensuring that a crisis plan is in place and on file with the LME and the identified provider for all IDD/MI or IDD individuals who have transitioned back to the community.
- Ensuring (to the extent possible) that additional state dollars are available to all IDD/MI individuals as needs are identified.

TCM Provider Functions Related to Transition of Individuals from State Operated Facilities to the Community Using CAP-MR/DD Waiver Funding

As the clinical home for individuals with IDD, the case manager's fundamental role is to ensure that the transition process is a smooth one. The coordination of transition to the community requires vigilance and attention to detail. When an individual has been identified as appropriate for movement to the community with waiver funding and supports, the LME must initiate the process and make a referral to a TCM provider agency. The following process must occur:

- The case manager must be in ongoing communication with the developmental center transition coordinator or hospital liaison for the completion of the MR2 and to agree upon a projected discharge date since the effective date of the MR2 must be the date of discharge from the center or hospital. (The developmental center transition coordinator or hospital liaison should coordinate completion and signing of the MR2, sent to the center by the case manager, by a state operated facility physician or licensed psychologist.)
- Once the MR2 is completed and signed, the case manager is responsible for submission of the MR2 to the LME who will then sign the MR2 and submit to the Murdoch Center, along with a psychological evaluation that includes an adaptive functioning assessment, for determination of ICF-MR Level of Care (LOC). Note: The MR2 is valid only for 30 days from the date of signature of the physician or licensed psychologist.
- The case manager has the responsibility for projecting a date of discharge in collaboration with the transition coordinator or hospital liaison. Once that date is established, Murdoch Center is notified in order to indicate the effective date of the MR2 to be the date of discharge.
- Once the LOC is determined, the case manager begins development of the waiver Plan of Care immediately. (Under new federal rules, individuals may be considered to be transitioning to the community during the last 60 days prior to discharge as long as the case management functions do not duplicate discharge planning and the institutional stay has been 180 consecutive days or longer. For a covered, short-term, institutional stay of less than 180 consecutive days, individuals may be considered to be transitioning to the community during the last 14 days before discharge with the exception of individuals ages 22-64 who reside in an institution for mental disease (IMD). Billing for case management related to transition would not be payable until the date that an individual leaves the institution, is enrolled with the community case management provider, and receiving medically necessary services in a community setting.) This will include the development of the Plan of Care using assessment information provided by the state operated facility to serve as the basis for the planning process. The Plan of Care should be developed in collaboration with the guardian, identified residential provider and other identified individuals. As noted in Implementation Update #36, an assessment completed by a state operated facility can fulfill the requirements of a comprehensive clinical assessment (required for all new individuals to the system) if it contains all of the required elements. For individuals with co-occurring mental illness, ensuring the inclusion of appropriate psychiatric supports is required.
- The Plan of Care must include a comprehensive crisis plan developed in collaboration with the state operated facility to ensure that potential crises upon returning to the community are addressed or anticipated. For individuals with challenging medical needs, explicit information must be included addressing potential issues and how they will be addressed. For individuals with challenging behaviors a behavior support plan must be developed, or be in the process of development, with assurance of ongoing monitoring by a licensed professional upon return to the community.

- Once the Plan of Care has been completed, it must be submitted to Value Options with a cover letter indicating that the plan is for an individual transitioning to the community from a state operated facility, a request for expedition of the approval, and identification of the intended discharge date in order for services to be approved and available upon discharge. The authorization date will be the date of discharge from the state operated facility.

TCM Follow Up Responsibilities

- The case manager is responsible for informing the LME DD POC of progress toward transition to the community and notification once the move is complete.
- As the clinical home for individuals with IDD, case managers have first responder responsibilities including phone and face-to-face access, and with a focus on prevention and proactive crisis intervention based on the established crisis plan.